

## ATTACHMENT #7

### MODEL DENIAL OF PAYMENT/NOTIFICATION OF APPEAL RIGHTS LETTER

Attachment #7 is a model letter of denial of a payment that includes the rationale for the negative decision and a notification of the applicant relative caretaker's right to appeal the negative decision to the state Division of Hearings and Appeals.

Again, this is a model letter and is not mandatory. We strongly recommend, however, that any other letter or other notification used by an agency contain this information.

## MODEL LETTER OF NOTICE OF NON-APPROVAL OF KINSIHP CARE PAYMENT

(Date)

(Name and Address of Kinship Care Applicant)

Dear Mr./Ms./Mrs.

(Kinship Care Applicant:)

We have reviewed your application for a payment under the Kinship Care Program. Unfortunately, we are unable to approve your application. Our decision to not approve your application was made for the following reason(s):

- a.     \_\_\_ There is no need for the placement. [s.48.57(3m)(am)1.]
- b.     \_\_\_ The living arrangement is not in the best interests of the child(ren).  
          [s.48.57(3m)(am)1.]
- c.     \_\_\_ The jurisdictional criteria under s.48.13 or 938.13 are not met currently and we  
          do not believe that they will be met in the future. [s.48.57(3m)(am)2.]
- d.     \_\_\_ The criminal background requirements are not satisfactorily met.  
          [s.48.57(3m)(am)4.]
- e.     \_\_\_ You have not attested that neither you, another adult living in the  
          household nor any individual in your employ has any arrests or convictions that  
          could adversely affect the child or your ability to care for the child.  
          [s.48.57(3m)(am)4m.]
- f.     \_\_\_ You have not cooperated with this agency in the application process.  
          [s.48.57(3m)(am)5.]

Should there be any change in any of the circumstances identified above as being the cause of this decision, you may reapply for a payment under this program.

You may appeal this decision unless the decision was based on item d. above. If you would like to appeal this decision, you must submit a written request to the state Division of Hearings and Appeals at P.O. Box 7875, Madison, WI 53707. You must request such an appeal hearing in writing within 21 days from the date of this letter. Any request for appeal received by the Division of Hearings and Appeals after 21 days from the date of this letter will be denied.

Should you have any questions regarding this decision, please contact me at (    ) \_\_\_\_\_

Sincerely,

(Name of Agency Contact Person)

(Name of Agency)